with what he has to say, but he should certainly make them think again about certain too-facile assumptions and test the basis of their case. No less important is the way in which he challenges the hypnotic spells of the phrase-makers. "Social Medicine" is a fine-sounding term but it has yet to be adequately defined. The concept of "total environment" is in line with the philosophy of Chadwick and yet not foreign to that of Ryle; perhaps Jervis is offering the very bridge which is needed for the gulf between present ideologies.

THE HEALTH AND SOCIAL WELFARE OF IMMIGRANTS IN BRITAIN

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IN the past, Flemings, Huguenots, émigrés from the French Revolution, political refugees of the 19th century, and Jews came to seek asylum in the British Isles; except for the limited restrictions imposed by the Aliens Act of 1905 on those "without means" (and then not if they were fleeing from persecution) the right of asylum was, up to 1914, sacrosanct. After 1918 free entry was restricted and the Government allowed the immigration of indigent refugees without formality only to Basques and Jews in the 1930s, displaced people, especially Poles in the 40s and Hungarians in 1956 (Wilson, 1959).

HISTORY OF THE IMMIGRATION OF COLOURED PEOPLE

We first hear of coloured people coming to England in 1555 when John Lok, a London merchant, brought five "Blacke Slaves" from the Guinea Coast. From about 1659 onwards, numbers of young Africans were brought to England and kept in London as domestic servants, their possession being regarded as a mark of social distinction (Banton, 1955(*a*); Richmond, 1955).

As a result of the now famous Mansfield Judgment in 1771, it was formally declared that the state of slavery was untenable by the law in Britain. This legal decision, however, made little difference to the social status of negroes, and at the end of the war with the American Colonies there was an increase in the numbers of coloured beggars and others who found themselves destitute in London. A committee "For Relieving the Black Poor" was set up, and over

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400 negroes were returned to Africa to found a settlement afterwards known as Freetown. However, many coloured people remained in this country.

The 1914–18 war led to a great increase in the numbers of coloured men in Britain. Many seamen deserted or left their ships to take up shore work at high rates of pay. Others were recruited in the labour battalions for overseas service and were later demobilised in Britain.

After the war the shipping industry contracted, and with the demobilisation of ex-servicemen, the level of unemployment rose. Coloured men who signed on at colonial ports were faced with open hostility from many white seamen. In 1919 rioting broke out in Liverpool, Cardiff, Newport and Glasgow, and as a result several hundreds of coloured men were repatriated to West Africa. In 1929, the first investigation into the social and economic status of coloured people took place in Liverpool, and this was followed by a further survey in 1938. It was found that 75% of the males in coloured families were unemployed, a percentage very much higher than among white males in similar occupations. Coloured families tended to fall below the "poverty line", and there was a tendency for rents to be raised when tenants were coloured.

Since 1945 the pattern of immigration has changed, and from 1950 onwards most of the coloured workers entering this country have come from the West Indies, although there have been considerable numbers of Indians and Pakistanis. Up to 1951 fewer than 1,000 people from the West Indies entered the United Kingdom yearly, but in 1952 this figure rose to slightly over 2,000, and this was equalled in 1953. In 1954 and 1955 10,261 and 24,473 West Indians respectively arrived in this country, and at the end of 1955 there were believed to have been 100,000 coloured workers in Great Britain of whom, perhaps, 57,000 were from the West Indies, especially Jamaica, and about 30,000 to 40,000 from India and Pakistan.

Before the new migration began there were coloured communities in London (the Stepney area), Cardiff (Bute Town), Liverpool, and North and South Shields. In 1953 the principal communities were Brixton, Camden Town, Stepney and Paddington in London, Balsall Heath in Birmingham, Moss Side in Manchester, and smaller settlements in Liverpool, Leeds, Sheffield and Nottingham. Later an even wider dispersion of migrants occurred, and in 1956 Senior and Manley reported that about 40% of the migrants were in London, 30% in the midlands, 18% in the north-west, 9% in the north-east, and 3% scattered.

Statistics in recent years are difficult to establish, but the following table has been compiled from information supplied by the Migrant Services Division of the West Indian High Commission, and from answers to parliamentary questions.

Between 1945 and 1959 Irish immigrants (353,000) exceeded immigrants (333,000) from all other Commonwealth countries. On the other hand, the numbers of emigrants fell from 230,000 in 1957 to 130,000 in 1960.

TABLE I
NET INWARD MOVEMENT OF IMMIGRANTS

Year	West Indies	India	Pakistan
1956	26,441	5,500	2,000
1957	22,473	6,600	5,200
1958	16,511	6,200	4,700
1959	20,397	2,900	900
1960	52,655	5,800	2,500

In December, 1958, the coloured commonwealth population was reported to be about 210,000 of whom 115,000 were West Indians; 25,000 West Africans and 55,000 Indians and Pakistanis. In addition there were 19,000 colonial students, including 6,000 from West Africa and 5,000 from the Caribbean. In 1959 the Institute of Race Relations organised an investigation into the problems of coloured immigrants in Britain, and reported that while London had the largest coloured population (90,000) the other main centres were Birmingham (25,000 to 30,000); Liverpool and Manchester (8,000 to 10,000) and Nottingham (4,000 to 5,000). The totals of immigrants into this country in 1961, are compared with the totals for 1960 in the following table.

TABLE II

Country	1960	1961
West Indies	49,650	66,300
East Africa	250	2,650
West Africa	500	5,450
Cyprus	3,200	6,850
Malta	1,400	500
Hongkong	500	2,150
Malaya	400	700
Singapore	50	950
India	5,900	23,750
Pakistan	2,500	25,100
Ceylon	1,100	650

REASONS FOR MIGRATION

Migration in recent years is part of the general movement of people to urban centres in all parts of the world, which has been intensified, as far as Britain is concerned, by a post-war labour shortage (Stephens, 1956). Parts of the Commonwealth, like Jamaica, East Pakistan and areas of West Africa are the distressed areas of the 1950s. In recent years unemployment in Jamaica has been as high as 20% and work tends to be seasonal especially in sugar plantations. Wages are low and housing conditions are poor. It has been stated that

the capital cost of finding a factory job for an unemployed Jamaican is £2,000 and the cost of shipping him to Britain to find one is £100.

Other factors in increasing immigration from the West Indies, India, Pakistan and West Africa have been, firstly, the ambition of many to acquire a skill (comparable to those of higher education who come here for university studies) by training and experience, and thus to improve their prospects when they return home, secondly prestige, and thirdly the attractions of town life or marriage to English girls.

In the past, the West Indians have moved to Costa Rica, Panama, Cuba and the United States of America, but these trends have declined in recent years, and, in the case of the United States, have ceased since the passing of the McCarran Act.

PATTERN IN THE MIDLANDS

Before the outbreak of war in 1939, there were small numbers of Pakistanis and Indians living in the Balsall Heath area of Birmingham. There were very few negroes. During the latter half of the war, United states negro troops used to visit the city, and a number of coloured professional people formed a league of people of African descent to arrange hospitality for them (Banton, 1955(*b*)).

After the war many West Indians who had been stationed in the vicinity returned and settled there. West Indians frequently settled in the out-lying parts of Birmingham, but some Africans and West Indians gathered in the Balsall Heath district. In March, 1950, a Co-ordinating Committee for Overseas Nationals was set up in Birmingham, and in 1953 urged the appointment of a welfare officer charged with the welfare of the coloured population in Birmingham and the establishment of an information office for dealing with their problems. The city council agreed in June, 1954, to the appointment of a liaison officer for coloured people, and this officer, and his successor, working in the town clerk's department, have done valuable work in helping the growing number of immigrants in obtaining accommodation and employment in the area.

Immigrants have, in general, been law-abiding citizens, but there have been isolated reports of addiction to opium and Indian hemp. Most of the immigrants in the early 1950s were men between 20 and 45 and only about 10% of the Indians and Pakistanis, and 20 to 30% of the West Indians were women. In the last four years about 50% of the West Indian immigrants have been women and children.

Mixed marriages are uncommon, except in old-established coloured communities, but semi-permanent or temporary liaisons between coloured men and white women are not unusual, and white women, both married and unmarried, play a steadying and fostering part among recent arrivals. Coloured school children seem to meet no serious difficulties, although special classes have

sometimes been organised for pupils handicapped by an imperfect knowledge of English.

LOCAL STUDIES

(*a*) *A Midland County Borough: Population (1951): 87,210: 1955–57*

(Skone and Cayton, 1957)

Early in 1955 it became apparent that there was an increasing number of people from other Commonwealth countries living in the borough, and in June visits made by public health inspectors showed that 39 houses were occupied by immigrants; the population was nearly 450, about 260 of the occupants being Indians and Pakistanis and 184 being West Indians. Later the influx of coloured persons continued, and a further survey was made between May and July, 1956; the population had now reached 838 persons, made up as follows:—

TABLE III

	Men	Women	Children	Total
West Indians	336	143	26	505
Indians ...	232	10	6	248
Pakistanis ...	73	9	3	85
	641	162	35	838

Most of the houses occupied by coloured people are of the larger Victorian type and generally in good structural condition, but 15 of the 72 houses were included in the council's slum clearance programme.

While West Indian landlords let their houses exclusively to their own countrymen, most Indian landlords had West Indian lodgers. A number (about half) of the West Indian households included women and children, but the Indian and Pakistani immigrants are mainly men, with the result that the condition of their houses deteriorated. The houses occupied by coloured people were found to be used very fully, as can be shown from the following table.

TABLE IV

	Immigrants	Town as a whole
Persons per household	11·69	3·56
Persons per room	1·77	0·84
Percentage of persons living more than 2 per room	50·22	4·66

(Average number of rooms per immigrant house = 6·6)

A survey was made of the health and welfare problems encountered in the area.

(i) *Infectious Disease*

Between 1951 and 1956 17 immigrants were found to be suffering from tuberculosis. These patients came from 15 different addresses in the town, and at the beginning of 1957 three were still in hospital, nine were under observation, and of eight nothing was known. The notifications of the disease can be summarised in the following table:—

TABLE V

	1951	1952	1953	1954	1955	1956
Indians	–	–	1	–	4	5
Pakistanis	1	2	–	1	2	–
West Indians ...	1	–	–	–	–	–

Although the evidence was incomplete, there was nothing to suggest that any of these patients was suffering from tuberculosis on arrival in the United Kingdom.

Coloured persons formed the majority of patients examined in local special treatment clinics in 1955 and 1956. Acute gonorrhoea was the condition most commonly seen, and West Indians formed the majority of patients. Repeated evening visits were necessary to ensure that male patients attended the clinics for the full period of treatment and surveillance.

Eye diseases, including pterygium and corneal ulcer, were common and cases of trachoma had been reported. A number of patients suffering from hookworm disease had been treated in local hospitals. One Indian who later returned home was found to be suffering from non-infectious leprosy, and another immigrant, who had arrived in this country one week earlier, was admitted to hospital in 1954 suffering from typhoid fever.

(ii) *Mental Illness*

Six immigrants—three men and three women (two from West Africa, two from India, one from Jamaica and one from Pakistan)—had been admitted to psychiatric hospitals in the area, and the conditions treated included schizophrenia (2); catatonia (2); manic depressive state (1) and puerperal depression (1).

(iii) *Care of Unmarried Mothers*

Nine Jamaican women, aged from 17 to 25 years, consulted the moral welfare worker. Four were known to have been pregnant when they arrived in this country.

(iv) *General Child Care*

Twenty-five of the immigrant children were born in this area. The distribution is shown in the following table.

TABLE VI

Year of birth	West Indian		Indian		Pakistani		Born at	
	M.	F.	M.	F.	M.	F.	Home	Hospital
1952	–	–	–	–	1	–	1	–
1953	–	1	–	–	–	1	1	1
1954	2	1	–	–	–	–	–	3
1955	2	2	–	1	–	–	2	3
1956	4	6	2	2	–	–	1	13
	8	10	2	3	1	1	5	20

The standard of child care was generally quite satisfactory and several of the children were brought by their mothers to local authority clinics. Some of the mothers worked in local factories, leaving their children in the care of friends. In three other houses where young children were reported to be living, it was found impossible to make any satisfactory contact with the mothers, largely because of the language difficulty.

(b) A West Country City and Port, 1959-61

The city played an important part in the slave trade in the 18th century, but at no time is there any evidence that slaves were actually shipped through the port. The usual procedure was for cloth and trinkets to be shipped to West Africa, and slaves taken direct from Africa to America and the West Indies, where they were exchanged for commodities such as rum, sugar and tobacco which were brought back to the port.

There is scanty evidence of negro slaves in the city who were the personal house-servants belonging to individual merchants engaged in the slave trade. In the early years of the 18th century, there were advertisements in local newspapers for the sale of slaves (23rd June, 1750: "To be sold, a Negro boy about 10 years old. He has had the smallpox"), and for the recapture of runaways.

In the second half of the 18th century, Liverpool had become the leading port to deal in the slave trade and by the 1790s the slave trade in local ships was said to be "expiring", and by the time the Abolition Act was passed, not a single slaver left the port. With the end of the trade, the negro slaves who worked in the city also disappeared.

Although the city is listed as one of the ports with a long-standing coloured community there is no evidence of an old coloured settlement. After 1945 a

number of West Indians who had served in the R.A.F. settled in the city, but until the 1950s there were very few coloured residents.

During this period, some coloured men came to the port as stowaways and their numbers reached a peak of 104 in 1950. Since then the number of stowaways reported each year has declined and few of these men settled in the city. In the early 1950s, therefore, the increase in the number of coloured people coming into the city from other parts of this country was quickly noticed.

It was believed that in March, 1956, the total of coloured people (mainly West Indians) was 500; in March, 1957, about 1,000; in March, 1958, over 1,500, and in March, 1959, 2,000 to 2,500 (Hood, 1959). It was estimated at the end of June, 1960, that approximately 3,500 West Indians lived in the area, an increase of 1,500 on the figure at the end of December, 1959. The West Indians came mainly from Jamaica, Barbados and Dominica, and there were also a number of Indians, Pakistanis, Africans and people from various other areas of the East.

In November, 1961, the total immigrant population was about 5,000, of whom 220 (105 men and 115 women) were unemployed. Immigrants made up about 3% of the employees of one large factory of 3,000 workpeople and in a psychiatric hospital containing 1,122 beds there were 71 West Indians on the staff (1 staff nurse, 8 student nurses, 53 nursing assistants and 9 domestic assistants). There was a small number of overseas University students including some from the Caribbean and one West Indian had recently been President of the Students' Union. West Indians had trained and been employed as health visitors.

The first home of recent immigrants to the city was often a house in multiple occupation and, since the choice of accommodation was restricted, it was found that when one or two houses were occupied in this way in a street, other houses that became available in the neighbourhood were similarly used. Facilities for cooking (often on landings or under stairs) and lavatories must be shared and, because few of the rooms had electric or gas points, heating was often by means of obsolete and unguarded paraffin stoves.

Despite the poor living conditions and unfamiliarity with current views on infant feeding in Britain, the standard of child care was generally satisfactory. "Solids" were not introduced early enough and vitamin supplements were rarely given to babies and young children. Iron-deficiency anaemia was not uncommon and two cases of mild rickets were reported. Play material and toys were inadequately provided and young children spent too much time in hot and ill-ventilated bed-sitting rooms. During 1960 119 out of 137 immigrant women were confined in hospital and, although immigrant children were admitted to day nurseries on the same criteria as the children of long-standing city residents, 28 of 294 children on the registers of day nurseries in June, 1961,

were of West Indian parentage. There were more than 1,500 immigrant school children.

During 1960, 61 West Indian children, mostly aged less than five years, came into the care of the Children's Committee for temporary periods ranging from two weeks to three months, often when their mothers were admitted to hospital for confinement.

Although four out of five immigrants notified in the city as suffering from pulmonary tuberculosis in the year ending September, 1957, appeared to be infected before entering the country, only two cases (one West African and the other a West Indian) had been reported since 1959. The incidence of gonorrhoea among West Indian men was higher than in the resident population, but, although the immigrant population increased substantially in 1959 and 1960, the number of West Indian men treated rose only from 131 to 153, in each year 47% of the total. Mental illness was uncommon among immigrants, but 17 West Indians had been treated as in-patients in a psychiatric hospital in the past five years.

Blood samples from 135 coloured women were screened for the presence of abnormal haemoglobins. Assuming the coloured male population was of similar make-up there would be a low incidence of sickle cell anaemia (about 0·04%) and Hb. SC disease in the children (Raper, 1961).

Among immigrant expectant mothers there was a higher incidence of anaemia reported both early and late in pregnancy, possibly associated with failure to take iron that had been prescribed. They had a lower incidence of toxaemia, but poor resistance to complications.

DIFFICULTIES FACING IMMIGRANTS

(Senior and Manley, 1956)

(*a*) *Housing*

Inquiries in Birmingham, West Bromwich and Wolverhampton have disclosed that immigrants frequently live in houses in "twilight" areas of industrial boroughs (*i.e.* those which are showing signs of decay but not having reached the level of unfitness). Some make inadequate enquiries and purchase houses which may, within the next few years, be represented as unfit for human habitation. Living conditions have been vividly described by Carne (1961).

(*b*) *Making a Living*

Many migrants, particularly West Indians, are disappointed at their inability to obtain a position in this country of the same kind as they held in their own country. Many of the migrants depend on friends, relatives and other informal sources of information about job openings and they lack knowledge of the services available to them at the Labour Exchange.

(*c*) *False Impressions of Income and Expenditure in this Country*

There is much disappointment and distress over the level of wages earned and the small balance left over after expenses are met. Although it has been reported that about half the migrants from Jamaica had borrowed money for either all or part of their air or boat fare, a British Institute of Public Opinion survey reported that 70% of migrants had paid their passage out of their own resources.

(*d*) *Climate and Food*

Nearly one in five of migrants questioned in a British Institute of Public Opinion survey complained of the climate, compared with 30% whose greatest problem had been in finding somewhere to live. Many reports were heard by Senior and Manley of West Indians leaving fairly well-paid jobs in the building trade because they could not stand the inclement weather of the spring or the autumn.

THE DESIRABILITY OF THE MEDICAL EXAMINATION OF IMMIGRANTS

All aliens entering the United Kingdom may be required to submit to an examination on their arrival by a doctor appointed as a medical inspector under the Aliens Order, 1953. Leave to land may not normally be granted if the medical inspector certifies that the alien's admission would be undesirable for medical reasons or because he is of unsound mind or mentally defective.

There are usually no restrictions on the entry and residence of British subjects, Commonwealth citizens, British protected persons or citizens of the Irish Republic.

Up to 88% of annual notifications of smallpox occur in India and Pakistan. The number of cases of the disease reported from Karachi port and airport increased from 18 in the week beginning 12th November 1961 to 130 in the week beginning 10th December ; there were 224 deaths in the City in 1961, 155 after 1st November (*Times*, 1962). In January 1962, international certificates of vaccination of all travellers, known to have originated from Karachi or spent a night there within the 14 days preceding entry to this country, were checked at London Airport by clinical examination. Anyone of whose protection the Port Medical Officer was not satisfied was vaccinated or, if vaccination was refused, isolated.

An examination by the Health Committee of the A.M.C. of the immigration laws of various European and Commonwealth countries indicates that the United Kingdom, Denmark and Holland are the only countries allowing immigration without medical examination. In other countries, admission is normally prohibited to persons suffering from physical or mental defects or diseases which may affect the immigrant's capacity to earn a living (*e.g.* blind-

ness, insanity, epilepsy) or from infectious or contagious diseases, such as trachoma or tuberculosis, which may constitute a menace to other persons and thus to the national health. It is a growing practice for the immigrants to be required to undergo the medical examination in their countries of origin, generally under arrangements approved by the consular authorities of the receiving country.

A report on "Elements of Immigration Policy", issued by the Population Division of United Nations in 1954, stated:-

> The development of standards for the inspection of immigrants with reference to health and physical fitness, and of methods of implementing these standards, is a major point in a well-planned policy of immigration. Without this precaution the danger of spreading infections is ever present. It is well known that in the past uncontrolled migration has played all too important a part in carrying infectious diseases to new areas. The last epidemic of cholera in England and Wales in 1866 was brought in by immigrants passing from Hull and Grimsby to Liverpool on their way to America. It is generally thought that the cholera outbreak in Hamburg in 1892 was in part due to the conditions in which the immigrants lived while awaiting embarkation.
>
> Even in modern times the great Haj pilgrimages and Hindu festivals are sources of great concern to both international and local health authorities. . . .
>
> Medical examinations have proved to be the key to healthful immigration. In order to assess the individual's capacity for spreading infection, his ability to work and the risks of his early death or disability, the physical and mental examination should be as complete as possible.

Several studies have shown an increased incidence of tuberculosis among recent immigrants to Britain. Of 2,547 Pakistanis and Indians examined at Bradford Chest Clinic 170 (6·7%) had tuberculosis. Among 2,611 workers (55%) sample in the catering trade in Soho, tuberculosis was more than five times as common as in the general population. The disease was twice as common among immigrants (9·6 per thousand X-rayed) as among those born in Great Britain; the Chinese who came mainly from Hongkong had by far the highest incidence of active disease (53·8 per thousand X-rayed) and were responsible for the increased incidence in immigrants as a whole. Rather more than half the tuberculous workers especially those from Hongkong, Italy and Ireland, had the disease before joining the trade.

There has been much discussion on the numbers of immigrants suffering from tuberculosis when they entered the country.

Of 123 Pakistanis and 27 Indians, mostly from the Bradford area, treated by Stevenson, only nine (6%) were known to have active tuberculosis on arrival in England. Of the three patients with post-primary lesions, two had

tubercle bacilli in the sputum; four of the six patients with relapses of old disease had been treated in Pakistan and the bacilli of one patient discovered to have gross bilateral pulmonary disease were drug resistant. Thirty-six patients (24%) developed the disease within 12 months of arrival and the remaining 105 within a period of one to five years (Stevenson, 1960).

On the other hand, Springett *et al.* (1958) found in Birmingham in the years 1956–57 that notifications of Irish-born persons as tuberculous were approximately twice as numerous as would be expected from the population figures. For Asian-born persons the notifications were between four and six times as numerous as would be expected, but for West Indians they were less than would be expected. The excess in the Irish born was probably due to the migration of uninfected young adults into a relatively more infectious environment, while that in the Asian born was due to the immigration of persons already having tuberculous lesions, 10 out of 36 patients having lived in England less than one year before notification, four less than three months. Of 35 Indian patients examined at Uxbridge Chest Clinic 12 probably had the disease—10 pulmonary and 2 non-pulmonary—on entry into the country (Roe, 1959).

In the Annual Report of the Central Health Services Council for 1959, it was stated that the Standing Tuberculosis Advisory Committee considered that nothing short of a system of strict medical control of immigration by the admitting country, was likely to be fully effective in removing the danger of the spread of tuberculosis in this country by infected persons entering it.

During 1960 the Committee analysed information obtained about the number of Asian immigrants who in September, 1960, had been in the country for less than a year and were being treated at hospitals and chest clinics. This showed an absolute reduction in numbers, compared with a similar survey in 1957, but the Committee thought that the latest figures were serious when considered in the light of the decrease in the number of immigrants from Asia, and of in-patients of all nationalities suffering from tuberculosis. (Central Health Services Council, 1960.)

A study by the British Co-operative Clinical Group, under the auspices of the Medical Society for the Study of Venereal Diseases, showed that during the period 1954–58 the number of cases of gonorrhoea at all the Clinics of England and Wales, rose by 60·5% for males and 54·1% for females. The clinics co-operating in the study provided information about the countries of origin of 68·7% of the national total in 1958 of cases in males and 55·6% of the total in females. Of the men 51·5% were born in the United Kingdom, 24% in the West Indies and 24·5% in other countries. Of the women 88·7% were born in the United Kingdom, 5·9% in the West Indies, and 5·4% in other countries. In those clinics from which complete information was obtained, it appeared that 55·9% of the incidence in gonorrhoea in males between 1952 and 1958

was attributable to men from the West Indies, but only 14·7% of the increase in females was due to West Indian women. From estimates based on a statement by the Home Secretary in September, 1958, on the number of coloured immigrants, it was calculated that the incidence of gonorrhoea per annum in West Indian men was 36·9 per thousand and in women 12 per thousand. These figures contrast with the calculated incidence among men and women of similar age from the United Kingdom of 1·1 and 0·4 per thousand respectively.

A review of patients suffering from leprosy seen in a hospital for skin diseases in London showed that 42 out of 79 patients examined came from India and three from Pakistan. The disease was diagnosed in the country of origin in 24 patients but in 55 patients the diagnosis was made in Great Britain, symptoms being present in 22 patients before they arrived in this country (Stevenson, 1961).

Miller and Bamforth (1961) reported that of 25 patients suffering from hookworm infestation, 12 complained of vague abdominal pains and 10 were anaemic, the lowest haemoglobin value being 2·7 g. per 100 ml. In a survey of 99 healthy coloured immigrants, they found that 13 had hookworm ova in their stools; three of them had mixed helminthic infestation, and there were nine others with *Trichuris trichiura*, or *Ascaris lumbricoids* infestations.

Five persons infected with smallpox were known to have arrived at London Airport from Pakistan between 16th December, 1961 and 11th January, 1962. All five had valid international certificates of recent revaccination. There were no secondary cases (up to 23rd January) from three of these persons and only one from the fourth. The fifth was a girl of nine, who had been successfully vaccinated in infancy. She arrived on 16th December, was admitted to the Bradford Children's Hospital on 23rd December with malaria and died on 30th December, with no clinical signs of smallpox, which was deduced on 11th January as soon as secondary cases occurred amongst her contacts in the hospital.

In a study of West Indian and European children aged from 4 to 23 months, it was found that iron deficiency anaemia occurred in 53·5% of the West Indian and 22·4% of the European children. It was possible that the West Indian children had diminished iron stores at birth and it was suggested that there was an inherent racial difference in haemoglobin levels in this age group (Davis *et al.*, 1960).

THE ORGANISATION OF MEDICAL EXAMINATIONS IN MASS MIGRATION MOVEMENTS

The 19th century and early 20th century saw the largest peace-time migration of people in known history—the populating of North America by the European. Heart-rending problems of immigrants (including children) were reported when

they were rejected at the American port of entry on account of some physical or mental disability. In 1913 20,000 would-be immigrants failed to gain entry to the United States and were sent back at the expense of the shipping companies. To prevent these fruitless journeys and the introduction of disease from Europe, the German Government established a ring of 13 control stations on the Eastern and Southern frontiers, where emigrants were medically examined and their baggage disinfected (*Times*, 1961(*a*)).

Mass immigration to the State of Israel began with the intake of the survivors of displaced persons' camps in Germany, Austria and Italy, and of those who had attempted in vain to enter Palestine between 1946 and 1948 and been detained in internment camps in Cyprus and Mauritius (Grushka, 1959). They were followed by Jews from Eastern Europe, the Yemen, Tripolitania and Iraq. No selection was made and everyone, including young, old and sick, were accepted and between May, 1948, and April, 1955, 745,353 people entered the country. Among early immigrants it was found that tuberculosis, syphilis, trachoma, shistosomiasis, malaria, tropical ulcer and ring-worm of the scalp were prevalent. Between 1948 and 1951 the incidence of active tuberculosis per thousand persons in immigrants from Turkey, Czechoslovakia and Rumania was 9·3, 5·1 and 4·7 respectively.

From 1952 onwards attempts were made to examine and treat prospective immigrants in their countries of origin and medical examinations were introduced in transit camps and in ports of emigration from Europe. In the larger transit camps teams of physicians and social workers planned the absorption and care of families where the bread winners required to be admitted to hospital because of conditions like tuberculosis or psychiatric illness, as soon as they arrived. Cases of chronic disease and requiring social support were dispersed as widely as possible among the healthy population all over the country.

In November, 1956, the Health Committee of the Association of Municipal Corporations recommended that all immigrants to Britain should be medically examined and there should be power to exclude those suffering from tuberculosis, mental illness and deficiency and any infectious disease. The Committee suggested that the examination, which should be made in the emigration country by a doctor chosen by the British Consul, should be in a prescribed form and include a chest X-ray and mantoux test. All who were shown to be susceptible to tuberculosis should receive a B.C.G. injection. Consideration should be given to diphtheria immunisation for children.

In December, 1961, the B.M.A. Council adopted recommendations that no immigrants should be admitted without compulsory X-ray examination, under the supervision of the director of an M.M.R. unit, a chest physician, or a radiologist, at port of entry. "If an immigrant who is found to be suffering from active tuberculosis refuses to accept treatment he shall not be allowed to remain in this country".

CURRENT PROBLEMS, THEIR SOLUTION AND THE FUTURE

At present, the total coloured population in the United Kingdom is less than 500,000, or less than one person in 100. In Birmingham (population 1,105,651) provisional statistics for 1960 indicate that of 20,777 live births, 1,926 were to parents of whom at least one was non-European, and it was estimated in 1961 that the coloured immigrant population was 43,000 (*Birmingham Christian News*, 1961). In Wolverhampton, an immigrant population estimated at about 3% of the town's total, provided over 25% of the admissions to hospital maternity beds on social grounds in 1960 (Galloway, 1960). In Nottingham arrangements were made for 445 mothers to be delivered in hospital because of unsatisfactory home conditions; most of them were immigrants, approximately half the number being West Indian (Dodd, 1960). It has been suggested in Birmingham that the coloured population "might almost double their numbers by natural increase in the next 10 years. It is thought no longer impossible to visualise a Birmingham in which one inhabitant in every 10 is either a coloured immigrant or has immigrant parents" (*Times*, 1961(*b*)). Unemployment amongst immigrants is about three times the national average.

Under the Commonwealth Immigrants Bill refusal of entry to those who can prove their ability to support themselves and any dependants without working, or who can show that they have a job to come to, is limited to four grounds—health, criminal record, security or previous deportation. These are set out in sub-section (3) of Clause 2 and paragraph (a) defines the health qualifications—"if it appears to the immigration officer, or to a medical officer, that he (the immigrant) is a person suffering from mental disorder, or that it is otherwise undesirable for medical reasons, that he should be admitted". Medical inspectors will be appointed by the Minister of Health in arrangement with the Home Secretary.

Local authorities could help the assimilation of coloured people by organising classes along the lines of those established at the Clifton Institute for Overseas People, Balsall Heath, Birmingham, in 1951. In this Institute two evening classes attended by 70 people were started for instruction in English and they have now been extended to include technical classes in mathematics, general arithmetic, woodwork and drawing. At present 700 people attending 50 classes are enrolled at the Institute and there is a staff of 28 teachers. Recreational activities including table tennis, darts, draughts and chess also take place. In West Bromwich special classes for non-English-speaking children started in January, 1958, and as soon as children were considered to be capable of fitting into the ordinary school situation they were transferred. During 1960 1,033 attendances at the classes were made out of a possible 1,074 (96·2%) and at the end of the year 30 children were still enrolled. In Reading a welfare officer for coloured immigrants has been appointed to give advice and assistance

in connection with housing accommodation, the welfare of young children and general problems that face newly-arrived coloured immigrants (Hughes, 1961). In Bristol and other centres, conferences on Citizenship for West Indian immigrants sponsored by the Commission in the United Kingdom for the West Indies, British Guiana and British Honduras, have been addressed by officers of statutory and voluntary bodies.

Voluntary organisations can undertake activities on a regional basis, and a Commonwealth Welfare Council for the West Midlands Area has been set up with the object of promoting the welfare of Commonwealth citizens living within the area of the West Midlands; assisting their assimilation within the communities in which they were employed and in which they resided; securing the co-operation of local authorities and other organisations, and raising funds enabling the Association to give advice, information or other assistance to Commonwealth citizens in the area. Subsidiary councils dealing with different racial groups were set up. The duties of the welfare liaison officer who was appointed, included social case work; assistance and advice to local authority departments and voluntary bodies; initiation of projects that might benefit immigrants and an attempt to promote a better understanding between local communities and the immigrants. During 1958 the officer dealt with the social problems of 495 people including 135 referred by local authorities or other organisations.

Housing societies have been established in Leeds, Birmingham, Bath and Nottingham. In Leeds the first of these special housing societies, Aggrey Housing Limited, was formed in February, 1955; it is registered under the Industrial and Provident Societies Acts, and is an offshoot of the Aggrey Society, whose object is to promote good relations between white and coloured workers resident and working in Britain. At the end of 1960 it was reported that the Society, in conjunction with the parent society, Leeds Tenants' Housing Society, who provided tenancies for many Africans and West Indians between 1950 and 1954, granted 110 tenancies to coloured immigrants and although many of them had since bought houses, the two societies still had 78 immigrant families as tenants (Aggrey Housing Limited, 1960). The Birmingham Friendship Housing Association was formed in 1956 and at the end of 1959 administered five properties providing accommodation for 60 adults and 30 children (Birmingham Friendship Housing Association, 1960).

Up to 1954 some local authorities had by-laws under which they could require owners of houses let in lodgings, if they were of a type "suitable for occupation by the working classes", to register them and observe certain minimum standards. The Housing Act 1961 (Section 22) enables local authorities to submit schemes to the Minister for the registration of houses in multiple occupation, at any time "not less than three years from the commencement of this act".

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